No stones felt in common duct. Pancreas hard and head as large as a fist. Tube drainage of gall-bladder with gauze to abscess cavity and right kidney pouch.

Drainage never very free, but patient did very well until tube was removed at end of three weeks. Then followed fever, enlargement of liver dulness, and slight jaundice, subsiding in a week. This was followed by an attack of pleurisy at the left base and later by the discharge from drainage sinus of numerous pieces of necrosed tissue, reported from the laboratory as probably fat necrosis. This continued for several weeks with general condition poor. Exploration of sinus and aspiration of left chest negative.

Second Operation.—Incision through scar. Adhesions freed. Cystic duct followed down to junction with hepatic, and found kinked and strictured. Hepatic and common duct unobstructed. Cholecystectomy; tube drainage of hepatic duct through stump of cystic. Fat necrosis very much reduced, though some small areas still present. Pancreas reduced to nearly normal size. Condition on table very bad, but reaction took place. Drainage free. Later purulent bronchitis and septic nephritis developed, ending in death on the tenth day. No autopsy.

RUPTURED ECTOPIC PREGNANCY DURING TYPHOID FEVER.

Dr. F. O. Allen reported the case of a woman who was admitted to the Women's Medical Ward of the Presbyterian Hospital February 22, 1907, and came under the care of Dr. Musser. She was 32 years old, was married, and had been ill for three weeks. She had menstruated last at about the time she was taken sick. The case seemed to be one of typical typhoid fever, with an unusually large number and wide distribution of rose spots.

The second day after admission some tenderness was noted on the left side of the abdomen. At about five o'clock the following morning, the twenty-fifth day of her disease, she complained of severe abdominal pain, her temperature dropped to 98°, her pulse became more rapid and very weak (at times imperceptible), and her respirations increased in frequency. Intestinal hæmorrhage was suspected and she was treated accordingly. An examination a few hours later showed that abdominal breathing was restricted; the abdomen was slightly distended, but not tender; peristalsis was present; there was no loss of liver dulness; there was no

dulness in the flanks. The Widal reaction was reported positive; the leukocyte count was 19,200. The temperature remained subnormal throughout the day. In the evening, the temperature rose again moderately; there was increasing tenderness of the abdomen; rigidity was not marked, but there was a distinct resistance, especially on the left side; she vomited; a bowel movement following an enema did not contain blood. Her general condition became very bad, but improved somewhat after copious injections of normal salt solution beneath the skin.

During the evening the patient was seen by Dr. Wharton, who agreed with Dr. Musser that operation was indicated, and that intestinal perforation was the condition probably present. The speaker was indebted to Dr. Wharton for the privilege of operating upon and reporting the case.

Operation was done twenty-one hours after the onset of acute abdominal symptoms. An incision was made through the right rectus muscle. The peritoneum showed black in the wound; when it was opened, large quantities of blood poured out. The ileum was drawn through the wound and inspected, but no perforation or other abnormal condition was found. On exploring the abdominal cavity, the pelvis was found filled with blood and clots, which were scooped out by the handful. A mass, the size of a small lemon, was felt, springing, apparently, from the left Fallopian tube. The uterus was enlarged to about the same size and was soft. The small mass had a distinct pedicle, and at its upper pole there was a rupture into which the finger could be passed. The pedicle was ligated with silk, the abdominal cavity filled with salt solution, and the wound closed. The mass was a thin-walled sack filled with clot. No fœtus was found.

The patient's condition was considerably better during the following day, but the temperature soon rose and remained high, the lungs gradually became œdematous, and she died on the fourth day after operation.

A complete autopsy was not permitted, but the wound was opened and the peritoneal cavity examined. No signs of peritonitis or other intra-abdominal lesion were discovered; there had been no further hæmorrhage.

Dr. Henry R. Wharton said when he saw this patient the question was the differential diagnosis between hæmorrhage from an ulcer and perforation. An enema brought away no blood,

hence perforation was considered probable, though it was noted that the pain was in the left side and that there was not marked rigidity of the right side.

DR. JOHN B. DEAVER asked if a differential leukocyte count had been made in the case reported by Dr. Allen. He operated in one case which proved to be typhoid hæmorrhage, the blood being confined to the intestine. There was absolute rigidity. The small intestine was found to be filled with blood and was not opened. The patient recovered.

DR. WILLIAM L. RODMAN cited a case in which typhoid perforation was diagnosed by two medical colleagues, who insisted upon operation, although he did not favor it. When the abdomen was opened hæmorrhage was found in the gut, but no perforation. The patient recovered from the operation, but died from a second hæmorrhage a number of days later. Autopsy showed there had been no perforation. If one opens the abdomen in these cases he is probably warranted under certain conditions in opening the intestine and searching for the bleeding point, but in general the chances are better if the hæmorrhage be allowed to take its course. There is not a large field for operation in typhoid fever and one is not warranted in opening the gut unless there are adhesions or thin places in the wall make the finding of the bleeding point reasonably sure after the opening has been made.

BONE METASTASES IN CARCINOMA OF THE BREAST.

DR. HENRY R. WHARTON read a paper with this title for which see ANNALS OF SURGERY for July, page 81.

DR. MORRIS BOOTH MILLER described a fracture following operation for carcinoma of the breast in a woman of 40, the thorough operation having been performed. The patient when coming from the seashore, where she was during convalescence, was holding on to the seat to steady herself while standing in a street car. A slight jolt was followed by sharp pain in the arm and examination revealed an oblique fracture of the humerus. This suggested a recurrence, though there was no thickening of the bone and only the signs of an ordinary fracture. Demonstrable metastases occurred and the woman died the following winter.

DR. JOHN B. DEAVER said that Osler in 1902 reported 16 cases of carcinoma of the spine following carcinoma of the uterus or breast.